

**Assessing the Individual Health Insurance Market in the Post-HIPAA Era:
A Review of the Literature**

by

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1. Introduction

By any measure, the individual health insurance market is much smaller than the group market. The number of people under age 65 who report individual coverage (about 16 million) is only about 10 percent as many as those who report employer group coverage (158 million). Insurers' total earned premiums in the individual market are about 16 percent of earned premiums in the insured group market, and the number of insurers selling coverage in the individual market is just one-fifth the number that sell in the group market. The population that is uninsured (about 42 million) outnumbers the population that buys individual coverage by more than two to one.

The small size of the individual market allegedly makes it “fragile”. Changes in insured lives and premium volume that would be minor in the group market represent a major change against the much smaller base of business in the individual market. Most insurers in the individual market cover very few lives, and any change in the market can affect their business profoundly.

However, because the individual health insurance market is a residual market, it is peculiarly subject to change. In general, people buy individual coverage only when they lack access to employer coverage and are ineligible for public health insurance programs. Growth in employer coverage especially can take significant business from the individual market, and it may take disproportionately the individual market's preferred risks — younger workers who can find a job with employer coverage.

Precisely because the individual market is a residual market, consumers in this market typically have no other source of coverage available to them. If they failed to find and keep individual coverage, they would be uninsured. In light of the importance of the individual market to consumers who rely on it, its fragility is highly problematic.

This paper reviews the available literature describing the individual health insurance market and the impact of state regulation on this market. The paper is organized as follows. Section 2 reports available estimates on the size of the population that buys individual health insurance policies and describes in general terms the sources of this reported coverage, including State high-risk pools. Section 3 reviews available information about the demographic and socioeconomic characteristics of the individually insured population. Section 4 considers evidence about individual insurance prices. Section 5 describes what is known about health status and health services use among the individually insured population relative both to the general population and to the employer-insured population. Section 6 reviews available information about the stability of demand for individual insurance coverage, including both evidence about turnover and estimates of price- and income-elasticity. Section 7 describes the supply side of the market, reviewing recent evidence about structure of individual health insurance markets in the states. Section 8 reviews the emerging empirical and qualitative literature assessing the impact of state regulation of individual health insurance markets. The paper is summarized in Section 9.

2. How many people buy individual health insurance?

Not surprisingly, different surveys of the population have produced different published estimates of the population with individual insurance coverage. Of these estimates (summarized in Table 1), the Current Population Survey (CPS) produces the highest estimates of the number and percent of the population with individual coverage: in 1998, an estimated 15.5 million Americans — nearly 7 percent of the population under age 65 and about 10 percent of the population who had private health insurance at any time during the year.

Both the Medical Expenditure Panel Survey (MEPS) and the National Survey of America's Families (NSAF) produce somewhat smaller estimates of this population than the CPS: approximately 11 million to 12 million persons — just 5 percent of the population under age 65. Differences in the surveys' questions, administration and sample designs all drive the differences in these estimates, as may small differences in how researchers have defined the reference population for published estimates (e.g., including or excluding members of the military and their families).

While all available sources suggest that the number of people with individual health insurance is small relative to either the full population or the employer-insured population, it accounts for a significant proportion of the population that is not insured either in an employer plan or a public program: probably more than 20 percent, and as much as 26 percent based on CPS data.¹

The CPS offers the only information (pending release of the 1999 NSAF data) about recent trends in the individually insured population. The number of persons reporting individual coverage in the CPS has declined continuously since 1993, when 16.6 million persons reported individual coverage (Fronstin, 1999). Although interpretation of this trend is complicated by changes in the CPS questioning and field administration, gradual growth in the number of people who report employer coverage has offset the erosion of coverage in the individual market.

In 1999, 28 states operated a statewide high-risk pool for individuals without group or public coverage, and who have been either denied coverage in the individual insurance market or offered coverage only at a nonstandard rate.² Twenty-two of these states use their high-risk pool to comply with HIPAA's group-to-individual guaranteed issue requirement, but only one (Alabama) restricts enrollment

¹In addition, population surveys may construe group coverage obtained through associations inconsistently. For example, individual coverage obtained through an association marketed at workplaces (e.g., to employees of automobile retail dealerships) may be reported as employer coverage. Others may report the same coverage as individual coverage. Because population surveys do not ask specifically about association coverage and insurers are not required (on the standard reporting form) to distinguish association business from other group business, there are no reliable estimates of the proportion of group coverage that is association business.

²Some state high-risk pools require individuals to obtain more than one denial in the open market. Others also admit individuals if they have been offered coverage only with an exclusion rider for care related to an existing or potential health condition. In practice, such persons are likely also to have been "rated up".

only to HIPAA-eligible individuals. Excluding enrollment in Tennessee's high-risk pool (which in 1994 was integrated into the TennCare program), approximately 101,000 persons nationwide were enrolled in the states' high-risk pools in 1999. Of these, nearly half (47 percent) were in either California's or Minnesota's high-risk pool.

Recent growth in high-risk pool enrollment has been significant (nationwide, more than 13 percent between 1998 and 1999), largely due to the enrollment of HIPAA eligibles in states that use their high-risk pools to comply with HIPAA's group-to-individual portability protections.³ However, in all states except Minnesota and Tennessee (see below), high-risk pool enrollment remains very small relative to the individually insured population.

Potentially due both to widespread public awareness of the TennCare program and to consolidation of the eligibility determination process in Tennessee, estimated enrollment in the high-risk pool segment of TennCare is nearly as great as enrollment in all other state high-risk pools combined. Currently (in fiscal 2001), an estimated monthly average of 94,164 enrollees in TennCare — about 7 percent of all TennCare enrollees — are eligible for TennCare only because they are uninsurable (Price Waterhouse Coopers, 2000).⁴

3. Who buys individual insurance?

On average, the population that reports individual insurance coverage is much like the general population under age 65. Most are adults of child-bearing age or children. Most live in families headed by a full-time full-year worker who receives a wage or salary, and is not self-employed. Most have family income above 300 percent of poverty, and most live in metropolitan areas.

However, the population with individual insurance is different from the general population — and perhaps more important for public policy discussions — from the employer-insured population in

³In some states with very low baseline enrollment in the high-risk pool, the recent rate of enrollment growth has been high (Communicating for Agriculture, 1998 and 1999). Alabama, Alaska, Arkansas, Montana, Oklahoma, Oregon and Texas all reported increases in enrollment between 1998 and 1999 that ranged from 40 percent (in Oregon) to more than 360 percent (in Texas).

⁴In a reorganization to become effective in fiscal 2002, TennCare will retain the State high-risk pool, but the financial management of this block of enrollees will be separate.

Table 1 Estimates of the Nonelderly Population with Individual Insurance, Selected Years			
Data source and coverage year	Number (in millions)	Percent of population	Estimated percent among population without employer or public coverage ^a
CPS: ^b			
1995	16.0	6.9%	28.4%
1996	16.0	6.8%	27.9%
1997	15.8	6.7%	26.8%
1998	15.5	6.5%	26.1%
1999	15.8	6.6%	27.3%
MEPS: ^c			
1996	10.7	4.6%	19.3%
NSAF: ^d			
1997	12.2	5.2%	25.2%
High-risk pool enrollees: ^e			
1998	0.1	0.6% ^f	0.2% ^g
1999	0.1	0.6%	0.2%
^a Author's estimates from published data. ^b March Supplement to the Current Population Survey, each year (Fronstin, 2000 and personal communication). ^c 1997 Medical Expenditure Panel Survey (Monheit and Vistnes, 1997). ^d Author's estimate from state program data, excluding Tennessee (Communicating for Agriculture, 1996-1998). ^e Estimated as the percent of the population with individual insurance. ^f Because CPS coverage estimates are used as the denominator, this estimate may be conservative.			

significant ways. Tabulating the 1998 Current Population Survey, Chollet (2000) observed that, compared to the employer-insured population, the population with individual coverage is:

- older (a larger proportion are adults, and their age distribution is older than that of employer-insured adults);
- have lower family income (a larger percentage are poor or near-poor, and fewer have income above 300 percent of poverty);
- more likely to live in smaller cities or rural areas;
- more likely to live in a family headed by a part-time or part-year worker, or a nonworker;⁵ and
- more likely to live in a family headed by a (usually unincorporated) self-employed worker (see Table 2).

⁵Compared to these CPS estimates, the NSAF data indicate that the individually insured population is substantially more likely to poor (15 percent in NSAF versus 9 percent in the CPS) and less likely to have family income at or above 300 percent of poverty (40 percent in NSAF versus 56 percent in the CPS). Persons who report individual coverage in NSAF are also more likely to be full-time workers (72 percent) than those that report individual coverage in the CPS (64 percent). Other distributions — including especially the age distribution of individually insured people — are comparable.

Moreover, published tabulations of other population survey data — the 1997 NSAF — indicate that the vast majority of individually insured workers (about 81 percent) are employed in firms with fewer than 100 employees. By comparison, just half of workers with employer coverage were employed in smaller firms (see Table 3).

In some states, a relatively high proportion of the population is individually insured, and they drive the national profile of people with individual coverage. In North Dakota, South Dakota and Nebraska, as much as 15 percent of the population has individual coverage during all or part of the year (compared to less than five percent in some other states — Massachusetts, Michigan, New Mexico, and Ohio) (Chollet and Kirk, 1998). The relative availability of employer coverage or public program coverage probably drives differences among states in the proportion of their populations that are individually insured. However, these differences may also relate to unmeasured supply characteristics in different markets: the particular products available, insurers' marketing and underwriting practices, the cost of health care and the price of health insurance.

Table 2 Sources of Health Insurance Coverage among the Nonelderly Population, by Selected Characteristics of the Insured Individual: 1997							
Population characteristics	Total population under age 65 (millions)	Employer-based insurance		Individual insurance		Uninsured	
		Percent of population	Percent of employer- insured population	Percent of population	Percent of individually insured population	Percent of population	Percent of uninsured
<i>Age:</i>							
Less than 18	70.8	63.7	28.8	5.1	22.9	15.0	25.0
18 - 24	24.9	56.8	9.1	6.0	9.5	30.2	17.6
25 - 44	82.8	69.4	36.3	5.9	31.1	20.0	38.9
45 - 54	34.0	74.3	16.2	8.2	17.9	13.8	11.0
55 - 64	22.2	65.7	10.0	13.0	18.5	14.1	7.4
<i>Family income as a % of poverty:</i>							
0-99 percent	32.7	18.2	3.8	4.1	8.7	34.4	26.4
100-199 percent	41.1	47.7	12.6	6.3	16.7	32.1	31.0
200-299 percent	41.1	71.2	18.7	7.2	18.9	18.8	18.1
300-399 percent	35.7	81.5	18.6	7.1	16.2	11.3	9.5
400 percent +	84.2	86.2	46.4	7.3	39.6	7.6	15.1
<i>Residence:</i>							
Metropolitan	183.4	67.6	79.7	6.2	73.1	18.2	78.4
Nonmetropolitan	51.3	66.7	20.8	6.6	26.9	18.1	21.6
<i>Work status of family head:</i>							
Full-time full-year worker	167.7	78.5	83.8	6.0	64.2	14.2	55.9
Part-time or part-year worker	44.4	46.5	12.9	8.9	25.4	28.5	29.7
Non-worker	23.2	20.1	0.0	7.0	10.4	26.4	14.4
<i>Type of employment of family head:</i>							
Wage or salary worker	194.8	73.7	91.8	5.1	64.2	16.6	76.1
Self-employed incorporated	8.3	69.6	3.7	18.4	9.8	12.8	2.5
Self-employed unincorporated	8.3	29.0	1.5	29.2	15.5	35.8	7.0
Unpaid workers or nonworker	23.3	20.1	3.0	7.1	10.5	26.4	14.4
Source: Chollet (2000)							

Table 3 Firm Size of Employment among Workers with Employer or Individual Health Coverage, 1997						
Firm size	Employer coverage			Individual coverage		
	Number (in millions)	Percent	Percent within coverage source	Number (in millions)	Percent	Percent within coverage source
0-99 employees	36.6	71.5%	51.7%	2.2	4.2%	81.0%
100-999 employees	25.0	87.8%	35.3%	0.4	1.5%	16.1%
1,000+ employees	9.2	93.5%	13.0%	0.1	0.8%	2.9%
Total	70.8	79.1%	100.0%	2.7	3.0%	100.0%
Source: Tabulations of the 1997 NSAF (Haley and Zuckerman, July 2000).						

4. The price of individual insurance

Published measures of individual insurance prices are rare. Because it is practically impossible to control for all of the factors that influence price — including especially benefit design — interpretation of even the measures that are available is generally suspect. However, several analyses have provided some insight into relative or absolute prices for individual insurance products:

- Tabulating data from the Health Insurance Association of America, Phelps (1992) examined the relative loading fees on commercial group and individual insurance — the component of price that exceeds the medical benefits paid by the contracts (and therefore implicitly controls for both benefit design and biased enrollment). Phelps estimated that the 1990 average loading fee on individual coverage (70 percent of medical benefits) was more than three times that on group coverage (20 percent of medical benefits). This estimate fell within the range of observed commercial loading fees between 1970 and 1985 add footnote on corresponding loss ratios.
- Examining the prices that large carriers in 7 states charge for individual coverage, GAO (1997) reported prices that ranged as high as \$532 per month for a product (with a \$500 deductible) in states that did not restrict rating practices. Considering age, gender and geographic area as rating factors (but not health status), prices for that product varied by more than 8 to 1: the carrier's highest rate (\$532) was more than 8 times the level of its lowest rate (\$65). Rate dispersion reported for three other carriers (before consideration of health status) ranged between 2.5:1 and 4.2:1.
- Chollet and Kirk (1998) reported standard rates effective in 1998 for selected health insurance products and carriers in 10 states. Not controlling for product type or benefit design, they observed substantial price variation across states. Standard rates ranged as high as \$460 per month (in Florida, for men at age 60) and as low as \$45 per month (in North Dakota, for men at age 25). Within states and products, Chollet and Kirk observed substantial price differences across gender and age categories. These differences (comparing standard rates for individuals

aged 60 versus age 25) ranged as high as 4.6 to one.⁶ In states where insurers may consider health status to rate coverage, effective prices may be much higher than standard rates — and insurers may set their underwritten rates strategically above the rate charged for coverage in the state high-risk pool.

However, neither the average loadings nor the standard rates reported in the literature are adequate indicators of the true prices that individuals confront when they have identified health problems. (In fact, how many people actually pay standard rates is unknown.) Chollet and Kirk (1998) observed “rate-ups” for health status that ranged from 75 percent to 200 percent in 1998. Moreover, in most states (where individual coverage is not guaranteed issue), they observed that insurers finally constrain rate differences within markets and products by denying coverage to individuals with more costly health problems or by issuing “exclusion riders” to exclude coverage for specific conditions for the life of the contract. Obviously, people who are able to obtain coverage only by claiming Federal or state protections — HIPAA or other state guaranteed conversion from group to individual coverage — are in less-preferred risk categories and may pay very high prices for coverage. Premiums charged to federally eligible individuals have been reported as high as 600 to 2,000 percent of standard rates (Pollitz *et al.*, 2000).

In addition to these factors, insurers in the individual market can engineer biased selection that can drive very high prices for individuals with health problems. Chollet and Kirk (1998) observed some carriers that routinely denied enrollment in their managed care option to applicants with health problems, instead steering them to the carrier’s fee-for-service option. Alternatively, in states that require insurers to sell a “basic and standard” insurance option (intended to help consumers comparison shop for insurance) but also allow insurers to sell other similar products, it is generally presumed that insurers try to use the standard product as a “dumping ground” for high-risk consumers, driving up its price. However, available evidence in Florida indicates that, at least in that state, insurers have not done so, at least not so successfully as to systematically drive relative prices.⁷

Finally, some insurers carry “closed” blocks of business in which prices typically spiral upward (GAO, 1997). Defined as a plan in which the insurer is no longer accepting new enrollment, a closed plan is naturally rated “durationally”: people in the plan pay more not only because they become older, but also as they remain in the plan longer. Insurers may expedite this spiral by raiding their own closed block, selectively offering enrollees in their closed block exit into another of their plans. In states that do not

⁶A recent review of individual health insurance rates in Maryland found 1999 rates in the same general range. That review included a catastrophic coverage product (with a \$10,000 deductible) priced from \$36 to \$58 per month, depending on age (Maryland Health Care Commission, 1999).

⁷A 1999 Lewin Group report to the Florida Division of Health Care concluded that the risk composition in insurers’ basic and standard product in Florida was not significantly different from the risk composition of the insured population overall (Ross, 2000).

require guaranteed issue, members of a closed health plan may be unable to obtain coverage from another carrier. In states with high-risk pools, insurers' closed blocks of business may ultimately empty into the high-risk pool. However, if the benefit design in the state high-risk pool is inferior to that in the closed-block plan, enrollees may struggle at phenomenally high prices to remain in the closed plan. In 38 states, regulators have discouraged insurers from running closed blocks of business by reviewing individual product rates actively — often restricting annual rate increases on all plans, open or closed (Kirk and Chollet, forthcoming).

Both the demographic and employment circumstances of the population with individual health insurance (described in Section 3) are consistent with a relatively high price for coverage, despite similar patterns of reported health status. Older individuals have generally higher health care needs and expenditures than younger individuals. Families that pay for coverage without a subsidy from their employer — and especially low-income families and families headed by workers with relatively unstable employment and earnings — are relatively likely to forego or drop coverage in response to changes in the price of coverage or changes in family income. This may lead to adverse selection that is undetectable from examination of only broad health status measures. Moreover, high turnover entails administrative cost to enroll and disenroll individuals from coverage. Health insurance supply characteristics also may affect the design and price of individual insurance products: for example, individuals in rural areas or small urban communities generally have less access to managed care, and they may be more likely to enroll in commercial plans than the population with access to employer coverage.

The sections that follow summarize available literature in several areas that have implications for the cost of individual coverage and potential relevance for public policy related to individual health insurance: health status and health services use among population with individual coverage; evidence of unstable demand in the individual market; and the characteristics of supply in this market.

5. Health Status and Health Service Use

While the population with individual coverage is more likely to be in excellent or very good health compared to the general population (Pauly and Percy, 2000), they appear to have about the same health status distribution as the population with employer coverage (Monheit and Vistnes, 1997) (see Table 4). As Pauly and Percy suggest, differences between the health status of the individually insured population and the general population may reflect insurers' success in medical underwriting — denying or limiting coverage to persons with health problems. However, the MEPS data suggest that insurers are not noticeably more successful in capturing a healthy pool of enrollees in the individual market (where

underwriting by insurers is notorious)⁸ than in the group market (where employers and insurers have less freedom to underwrite health risk). Early research on small group underwriting (Glazner *et al.*, 1994) suggests that insurers' underwriting practices (specifically, denial of coverage) may ultimately have little impact on the risk composition of insured lives in large risk pools, although it may be of considerable value to the majority of insurers that each (and collectively) write a very small volume of business.

Table 4 Reported Health Status Among Selected Population Groups by Source of Insurance, 1996							
Reported health status	CPS: 1996 ^a			MEPS: 1997 ^{b, c}			
	Total population	Individual coverage	Uninsured	Total population	Employer coverage	Individual coverage	Uninsured
<i>Percent of the nonelderly population in:</i>							
Very good or excellent health	69.6%	71.3%	61.6%	69.5%	74.3%	75.4%	62.8%
Good health	22.0%	20.8%	28.1%	21.4%	16.8%	16.8%	25.7%
Fair or poor health	8.4%	7.8%	10.4%	9.1%	8.1%	8.1%	11.5%
^a Author's estimates from published tabulations of the March 1997 CPS. Pauly and Percy (2000). ^b Author's estimates from published tabulations of MEPS. Monheit and Vistnes (1997). ^c Published tests of significant differences between the employer-insured and individually-insured populations are unavailable. However, small differences appear to be statistically insignificant.							

One reason that population surveys may detect no significant difference in the health status of insured lives in the individual market compared to either the group-insured population or the population overall may be that insurers can use multiple avenues to underwrite on health status other than denial or rate-ups (either of which might drive differences in health status among these subpopulations). Specifically, unless they are precluded by state law, insurers may write permanent "exclusion riders," excluding coverage for specific conditions for the life of the contract. Considering coverage among a sample of adults with chronic conditions in two communities in Indiana, one recent study (Stroupe, Kinney and Kniesner, 2000)) conclude that chronically ill individuals, when they are insured, are systematically underinsured. This study attributes the significantly lower level of coverage reported by individuals

⁸In its report to Congress describing health insurance markets in 7 states, the U.S. General Accounting Office (GAO, 1996) reported denial rates by large carriers that ranged as high as 33 percent (reported by a carrier in Illinois over its national book of business).

respectively with chronic conditions to permanent exclusion riders. While HIPAA now prohibits such riders in group policies, there is no corresponding protection in the individual market except for the time-limited protection extended to HIPAA-eligible individuals.

While both MEPS and NSAF capture information about health services utilization, only one report from these surveys offers estimates of health services use among the population with individual insurance separately from the population with employer-based coverage. This report (Brennan, 2000) considers health services use among low-income persons aged 55 to 64 and adjusted for selected sociodemographic and health characteristics (gender, race, marital status, health status, presence of a limiting condition, educational attainment and work status). An extract of that information is included below in Table 5; note that statistical tests of significance for comparisons of these populations could not be computed from published information.

Controlling for the various characteristics of the enrolled population, the employer-insured and the individually insured populations are similar in most measures of either access or utilization. However, people with individual insurance may be less likely to have a usual source of care (perhaps reflecting lower enrollment of individuals in managed care), and they report that they are less confident about their ability to access care. They may also be less likely to have visited a doctor, but (among women) more likely to have had standard preventive care in the past year than the employer-insured population.

6. Unstable demand for individual insurance: evidence of turnover and price elasticity

Although most of the population that reports individual health insurance report it as their only source of coverage during the year, about one-third report also having had private insurance from an employer (Chollet, 2000). The rate varies slightly between adults and children, and is generally higher among adults and children in income ranges above 200 percent of poverty — where family earners are more likely to obtain jobs that offer employer coverage (see Table 6).

Assuming that few people hold concurrent coverage from an employer and an individual plan, people who report both probably held individual insurance for only part of the year. Thus, it offers a rough (and conservative) measure of the annual rate of turnover in individual health insurance plans. As a percent of people reporting individual coverage, turnover in individual plans is about 10 times the rate estimated for the employer-insured population. Even so, this estimate of turnover fails to reflect entry and exit between individual plans and either uninsured status or public programs.

One aspect of high turnover in individual coverage (aside from gain or loss of access to employer plans) is the responsiveness of consumers to the price of individual coverage. Only one study has attempted to estimate the price elasticity of demand for individual coverage. Estimating the demand for

Table 5 Regression-Adjusted Health Care Access and Utilization among Low-Income Near-Elderly Adults (Ages 55-64) by Insurance Status, 1997		
	Employer coverage	Nongroup coverage
<i>Access:</i>		
No usual source of care	10.7	14.7
Unmet medical need	7.4	6.5
Unmet dental need	10.0	18.0
Unmet prescription drug need	6.6	5.6
Not confident in ability to access care	13.9	21.5
Not satisfied with quality of care received	11.2	11.2
<i>Utilization:</i>		
Any hospital visit	15.2	16.1
Any emergency room visit	23.1	22.1
Any doctor visit	80.3	73.6
Any dental visit	49.8	52.7
Any pap smear (women only)	47.8	56.4
Any breast exam (women only)	55.6	62.0
Source: 1997 NSAF tabulations (Brennan, 2000). Note: Tests of significance for differences between these populations were not provided.		

Table 6 Percent of Nonelderly Adults and Children with Both Individual and Employer-Based Health Insurance, by Poverty Status: 1996						
Family income as a percent of federal poverty	<i>Adults aged 18-64</i>			<i>Children aged 0-17</i>		
	Individual insurance, total	Employer-based and individual insurance	Employer-based and individual, as a percent of individual	Individual insurance, total	Employer-based and individual insurance	Employer-based and individual, as a percent of individual
0-99 percent	5.6	0.9	15.3	2.4	0.4	18.4
100-199 percent	6.9	1.6	22.8	5.3	1.2	22.2
200-299 percent	7.6	2.4	31.0	6.2	2.2	35.9
300-399 percent	7.6	2.9	37.7	5.9	2.4	40.2
400 percent +	7.8	3.1	39.8	5.8	1.8	31.6
Total	7.3	2.4	33.3	5.1	1.6	30.7
Source: Tabulations of the March 1997 CPS (Chollet, 2000).						

individual health insurance among workers without access to employer coverage in 1988, Marquis and Long (1995) concluded that their demand is very inelastic with respect to price (-0.3 to -0.4) and even more inelastic with respect to income (0.15).⁹

Various methodological problems with this study would suggest that both its price and income elasticity estimates are conservative.¹⁰ However, it may still be true that the purchase of insurance by workers without access to group coverage might appear to be insensitive to price. Historically, consumers have strongly preferred more comprehensive insurance products to various “bare bones” products (Chollet, 1992). Consequently, insurers typically write comprehensive products differentiated only by levels of cost-sharing, benefit exclusions (as state regulation permits) and internal limits on coverage for selected services. Therefore, the range of prices is relatively narrow and (because coverage

⁹The price elasticity of demand is defined as the percentage change in the quantity demanded per a one-percent change in the price. The income elasticity of demand is defined as the percentage change in the quantity demanded per a one-percent change in income.

¹⁰Marquis and Long (1995) estimated the price elasticity of demand among workers, using the March and May 1988 CPS data to identify workers who did not have access to employer coverage. They imputed health status to these workers from the Survey of Income and Program Participation (SIPP) and assigned health insurance prices to worker-observations based on one major commercial insurer’s standard rates, varied by zip code. These imputation methods entail potentially serious problems, probably the most serious being their imputation of standard health insurance rates without adjustment (other than imputed self-reported health status) for the likelihood of higher quoted rates or denial. Moreover, the analysis supposes a standard product design that may not have been available to some consumers.

is comprehensive) all prices are relatively high — eliminating many consumers from the market on the basis of income alone. Within the income range in which demand would be demonstrated, consumers might wish to respond to small differences in either price or income, but the practical opportunity is limited by the narrow range of insurance offerings. Furthermore, insurance products are complex, and consumers' downside risks in changing contracts can be high: they may find themselves exposed to unintended costs (for example, loss of their accustomed providers) if they fail to understand all of the differences in benefit design and administration. Finally, in nearly all states, consumers in the individual market face underwriting when they attempt either to enter the market or to change plans once they are in the market. All of these factors produce "cliffs" in supply that, unless adequately measured, might be construed as price- and income-inelastic demand. Thus, "natural experiments" are likely to give no real information about demand elasticity: consumers' insurance choices are narrow, the downside risk in moving between complex insurance contracts is high, and in most states underwriting practices limit consumers' ability to change coverage in response to either price or income.

7. The Supply Side: Who Sells Individual Health Insurance?

By any measure — number of persons covered, number of insurers selling coverage, or earned premium volume — the individual market is much smaller than the group market. Counting national insurers by the number of states in which they were licensed and sold individual products, 690 insurers wrote coverage in the individual market in 1997, compared to a group market total of 2,450 insurers (Chollet, Kirk and Chow, 2000). While large population states typically have many more insurers writing individual coverage, they have many *fewer* insurers per capital than small-population states.¹¹ In all states but one, the number of insurers selling group coverage outnumbered the number selling individual coverage.¹²

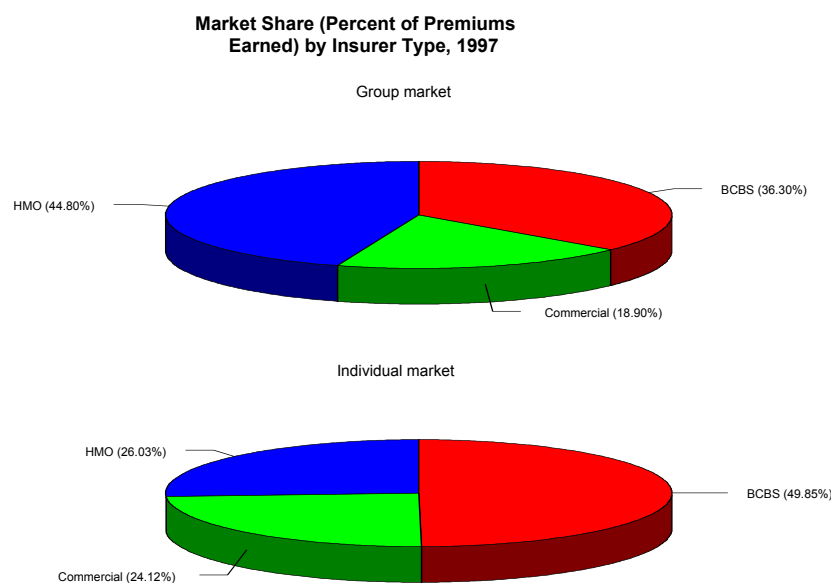
Measured nationally, BCBS was the dominant insurer in the individual market in 1995 through 1997 (Chollet, Kirk and Chow, 2000). Measured as premiums earned, BCBS plans (including BCBS HMOs) held nearly 50 percent of the individual market nationally and in all but 16 states. In four states (Idaho,

¹¹New York, Texas, and Florida had the largest number of insurers in the individual market (42, 40 and 28, respectively) in 1997. In contrast, six states (Rhode Island, Utah, Vermont, Delaware, Idaho and Alaska) and the District of Columbia had fewer than 5 insurers selling individual insurance products.

¹²In New York, nearly as many insurers — 71 percent — wrote coverage in the individual market as in the group market. Chollet, Kirk and Chow (2000) attribute the similar number of group and individual insurers in New York to a convergence of circumstances: HMOs accounted for nearly half of the insurers in New York's group market, and New York requires HMOs to write individual coverage.

Alaska, Kentucky, and Delaware), BCBS plans held more than 90 percent of the individual market.¹³ While HMOs held 45 percent of the group market nationally in 1997, they held just 26 percent of the individual market (see Figure 1).¹⁴

Figure 1



Source: Chollet, Kirk and Chow (2000).

While both the group and individual health insurance markets are concentrated among several large insurers in the state, the individual market in every state is the more concentrated. In 1997, just three insurers held 50 to 100 percent of the individual health insurance market in every state.¹⁵ Conversely, the smallest 50 percent of insurers held no more than 8 percent of the market in any state, and typically held less than 4 percent. Obviously, the high concentration of supply in the individual market among just a

¹³In contrast, BCBS held half or more of the group market in only 16 states, and 90 percent of the group market in only one state (Idaho).

¹⁴These categories of insurers are mutually exclusive. That is: BCBS includes BCBS HMOs, HMOs include only non-BCBS HMOs (but includes other nonprofit and for-profit HMOs), and commercial insurers include only for-profit insurers writing managed or unmanaged indemnity products (but not filing as an HMO).

¹⁵By comparison, in 1997 the largest three group insurers held 50 percent or more of the group market in 39 states (and the District of Columbia).

few sellers largely reflects the dominance of BCBS in many states. However, it also reflects HMOs' apparent difficulty in establishing and gaining market share when BCBS heavily dominates a market.¹⁶

Considering changes in the structure of supply in the individual market, Chollet, Kirk and Chow (2000) note two principal changes between 1995 and 1997. First, premium growth in the individual market was very slow — totaling just 6 percent over the period, compared to 19-percent growth in the group market. This pattern parallels the relative change in the number of people who report group versus individual coverage in the CPS over those years: the number of people reporting individual coverage declined by 10 percent, while the number reporting group coverage grew nearly 5 percent.

Second, while HMO market share grew in both the group and individual market between 1995 and 1997, it grew especially fast in the individual market. Between 1995 and 1997, HMO premium volume jumped 27 percent in the group market and 75 percent in the individual market; and HMO market share climbed nearly 10 points in the individual market (see Table 7). Nevertheless, HMOs dominated the individual market in only two states in 1997: California (where they held 64 percent of the market) and New York (where they held 51 percent).

Finally, while the individual market in every state has fewer insurers than the group market (including BCBS plans, commercial insurers and HMOs), it has many *more* insurers relative to premium volume. In 1997, total premium volume in the group insurance market was six times the premium volume of insurers in the individual market, but the group market had just 3 ½ times as many insurers (Chollet, Kirk and Chow, 2000). As a result, insurers in the individual market earned an average of \$11.9 million in premiums (per insurer), while group insurers averaged \$59 million in premiums.

In every state, the distribution of premium volume is highly skewed (just three insurers control at least half of the market), so that most insurers in the market survive on very little premium volume. Chollet, Kirk and Chow (2000) note that the very small premium volume earned by most insurers in this market and the strikingly lower average premium volume reported by insurers in small-population states both suggest that consolidation in the individual market may continue as insurers seek greater market

¹⁶In contrast, the study found no significant relationship between BCBS market share and commercial market share.

<p>Table 7 Group and Individual Earned Premium and Market Share by Insurer Type (Total U.S.), 1995 and 1997</p>						
Insurer type	Earned premiums (in billions)			Market share		
	1995	1997	Percent change, 1995-1997	1995	1997	Percentage point change, 1995-1997
<i>Group market:</i>						
BCBS ^a	\$47.2	\$52.6	11.4%	38.7%	36.3%	-2.5%
Commercial insurers	\$23.6	\$27.4	16.4%	19.3%	18.9%	0.0%
HMOs	\$51.1	\$65.0	27.1%	41.9%	44.8%	2.9%
Total	\$121.9	\$145.0	18.9%	100.0%	100.0%	- -
<i>Individual market:</i>						
BCBS ^a	\$4.1	\$4.1	-0.6%	53.5%	49.8%	-3.7%
Commercial insurers	\$2.4	\$2.0	-15.6%	30.6%	24.1%	-6.4%
HMOs	\$1.2	\$2.1	74.9%	15.9%	26.0%	10.1%
Total	\$7.7	\$8.2	6.8%	100.0%	100.0%	- -
<p>Source: Chollet, Kirk and Chow (2000). Note: Columns may not add to totals due to rounding. ^aIncludes BCBS HMOs.</p>						

share and greater economies of scale.¹⁷ This trend may drive greater market concentration, especially in small-population states. It may also challenge regulators to establish new ways of governing their health insurance markets in lieu of competition — potentially more as the states might regulate other essential, large-scale operations, such as public utilities and hospitals.

8. Impacts of individual health insurance regulation

Federal law governing individual health insurance is limited. HIPAA requires an avenue of access into the individual health insurance market for “eligible” individuals: people who have had at least 18 months

¹⁷All available literature on production economies of scale in health insurance suggest that insurers experience continuously declining marginal costs over a very long range of production, and the largest insurers experience just constant marginal costs. Studies of HMO economies of scale suggest increasing economies of scale among small HMOs until enrollment reaches about 100,000 lives (approximately \$150-200 million in earned premium), beyond which additional economies of scale are insignificant but not obviously declining (Chollet, Kirk and Chow, 2000).

of continuous coverage without a significant break, are leaving group coverage, have exhausted available COBRA benefits, and meet other requirements.¹⁸ HIPAA also requires guaranteed renewal in the individual market. HIPAA does not restrict the extent of preexisting exclusions in the individual market (either look back or waiting periods, as it does in the group market); nor does it require individual-to-individual portability or restrict insurers' rating practices.¹⁹

Either before or subsequent to HIPAA's enactment, many states had enacted requirements that exceeded HIPAA's provisions enabling access to coverage in the individual market (Chollet, Kirk and Simon, 2000.) As of 1999, 16 states required all insurers in the individual market to guarantee issue of either all products (7 states) or of a "basic and standard" product (9 states).²⁰ Most states — 34 in 1999 — restricted look-backs for preexisting condition exclusions, usually to 6 or 12 months; 35 states limited waiting periods for coverage of preexisting conditions, typically to 12 months (although only 13 states prohibited insurers in the individual market from issuing exclusion riders that permanently exclude coverage for specific conditions for the life of the contract.²¹

In fact, HIPAA prompted little real change in state individual market protections. Only four states took the opportunity HIPAA presented to enact broader guaranteed issue protections than they had in place previously,²² and only twelve states enacted HIPAA's federal fallback standard (all products guaranteed issue). However, even in these states, absent limits on rating, insurers can and have used premium rate-ups to deter access (Pollitz *et al.*, 2000).

Relatively few states limit insurers' rating practices in the individual market. In 1999, 16 states limited insurers' rating for health status; of these, eight states prohibited all rating for health status (that is, they

¹⁸ As mentioned earlier, 22 states complied with this provision of HIPAA by guaranteeing access to a state high-risk pool; other states guaranteed issue of all individual market products (the Federal fallback) to HIPAA eligibles; still others guaranteed access to a designated a statewide insurer of last resort, to conversion products, or to some other private coverage.

¹⁹ Federal laws passed after HIPAA included a number of other requirements related to maternity coverage, and coverage for cancer and mental health. As of December 1999, HCFA had notified 20 states and the district of Columbia about concerns that their statutes may not conform to Federal law regarding these provisions (U.S. General Accounting Office, 2000).

²⁰ These provisions apply to all persons. In contrast, some other states (for example, Iowa and Oregon) guaranteed issue of some or all products only to people who are previously and continuously insured, as per HIPAA's requirement.

²¹ In some states, interpretation of state law banning discrimination in the conduct of insurance may effectively curtail insurers from issuing riders to exclude coverage of maternity services or services for other specific conditions. However, this interpretation of state law appears to be rare (Kirk and Chollet, forthcoming).

²² New Mexico enacted new access to its small-employer health insurance purchasing cooperative where plans are community rated for federally eligible individuals. Georgia, Florida and Ohio strengthened their conversion laws to guarantee people leaving group plans access to better coverage for more affordable premiums than they could get prior to HIPAA.

required “community rating”). Nine states prohibited insurers from rating for individuals’ age, and 7 more states restricted the extent to which insurers can vary rates for age (variously, from 1.5:1 to 5:1). The prevalence of these reforms is summarized in Table 8. Note that many states have enacted some form of guaranteed issue without rating limits.²³ Conversely, others have enacted rating limits without guaranteed issue.²⁴

A number of studies have attempted to evaluate the impacts of these reforms. These include both empirical studies and case studies. The results of both types of analyses are described below.

A. Empirical studies of individual market reform

A growing number of researchers have investigated the impacts of regulation on the small-group market, but only three studies have investigated the impact of individual-market reforms on either coverage or the supply characteristics of the market. Aggregating across the group and individual health insurance markets, Zuckerman and Rajan (1999) estimate the concurrent impact of small-group and individual health insurance reforms on the statewide rates of no coverage and private coverage, respectively, in 1994. They concluded that guaranteed issue in the individual market increased the overall rate of uninsured, but could detect no significant impact on the rate of private insurance coverage (although the sign of the estimated coefficient was negative). A dummy variable for the presence of restrictions on preexisting condition exclusions also increased the rate of uninsured (with relatively low confidence), and decreased the rate of private insurance coverage (with high confidence).

Chollet, Kirk and Simon (2000) and Chollet, Simon and Kirk (2000) evaluated the impact of individual insurance market reforms in two studies: first with respect to measures of supply in the individual market, and then on the probability of having individual coverage among persons aged 18-64, conditional on having neither employer nor public coverage. Unlike Zuckerman and Rajan (1999), these latter studies constructed continuous variables for restrictions on preexisting condition exclusions (i.e., the maximum waiting period in law, in months) and rating restrictions (a function of the maximum rate bands, ranging from 0 to 1); and also differentiated between all-product guaranteed issue and some-product guaranteed issue. The latter study also considered individual-market regulation and coverage separately from that in the small-group market, and (because the fixed-effects model was estimated at

²³For example, the District of Columbia, Maryland, North Carolina, Rhode Island, Virginia and West Virginia.

²⁴For example, Louisiana, Nevada, North Dakota, New Mexico, Oklahoma, Utah and Washington.

Table 8 Number of States with Regulation Governing Access and Rating in the Small Group and Individual Markets, Effective as of 1999		
State provision	Small group market	Individual market
<i>Guaranteed issue:</i>		
All products ^a	49	7
Some products	0	9
Guaranteed renewal	50	50
<i>Limits on preexisting condition exclusions:</i>		
Maximum look-back period	49	34
Maximum waiting period	50	35
<i>Restrictions on rating:</i>		
Health status (prohibited or limited)	46	16
Age (prohibited or limited)	45	16
Composite	16	11
Source: Chollet, Kirk and Simon (2000) ^a In addition, 14 states permit self-employed persons access to the small-group market, and 37 have enacted “mini-COBRA laws that extend COBRA buy-in protections to employees in groups of two or more.		

the person-level rather than on state-wide coverage rates) it controlled for a large number of individual demographic and economic characteristics. Finally, it controlled for supply-side factors that might affect insurance prices, which were unobserved.

Chollet, Kirk and Simon (2000) found some impacts of individual market regulation on the structure of individual health insurance markets in the states. Controlling for year and state, they found that guaranteed issue of some or all products increased commercial insurers’ market share and reduced concentration of the market (measured as market share held by the largest five insurers). However, guaranteed issue of *all products* swamped this effect in the opposite direction: all-product guaranteed issue increased market concentration and reduced commercial insurers’ market share (although the latter effect was statistically weak). In addition, restrictions on health rating increased market concentration (as

measured by the Herfindahl index, but not top-five market share) and decreased commercial market insurers' market share.²⁵

These results can be interpreted in conflicting ways. If one presumes that a larger number of insurers is characteristic of a “healthy” competitive market, greater market concentration among a few large insurers could be viewed as problematic. However, most insurers in the individual market — and especially commercial insurers — arguably operate at inefficiently small economies of scale (Chollet, Kirk and Chow, 2000). Thus, greater market concentration could be viewed as a market adjustment to improve economic efficiency in the production of individual insurance.

Evaluating the impact of state regulation on the rate of individual coverage among nonelderly adults in worker families, Chollet, Simon and Kirk (2000) found that guaranteed issue of all products decreased the probability of individual coverage (by nearly 11 percentage points, controlling for all other factors), suggesting that insurance prices rose following implementation of guaranteed issue. However, the implementation of rate bands on health or age had no significant effect on coverage; nor did any measure of supply — although the signs of every estimated coefficient was consistent with greater market concentration (and, independently, the entry of HMOs) yielding lower prices and greater coverage.

In summary, the literature evaluating the impact of regulation in the individual market on either the supply characteristics of the market or coverage is new and emerging. To date, each study of this market has relied on early experience with market regulation, and also on very few observations of change. Nevertheless, these studies are provocative. Unfortunately, additional study of the individual market may yield little new information, absent continuing state reforms. In the small-group market, HIPAA forced many states to enact new regulation that would produce both a reason and empirical basis for new analysis. However, very few states have enacted additional reforms of their individual market since 1997 (the period of the latter two studies reviewed above) — although some have subsequently modified (or repealed) their reform legislation.

B. Specific state experiences

The following sections review the reform experience of six states: New Jersey, New York, Vermont, Washington, Kentucky and Massachusetts. Due to the wide divergence of the reforms enacted, their acceptance by insurers (and other organized constituents, including health care providers), and the paths of implementation, it is difficult to glean many general rules or lessons from these experiences. However, the stories of these states do make clear the importance of state context in interpreting the results of

²⁵Chollet, Kirk and Simon (2000) found no significant impacts on market structure from state laws requiring guaranteed issue, limiting waiting periods for coverage of preexisting condition exclusions, prohibiting or limiting insurers' from rating for health status, or from the presence of a high-risk pool in the state.

reform: in states that have had significant problems, typically the devil has indeed been in the details of the reforms or in the process of implementation. Finally, these stories illustrate the problems that most states have had in distinguishing real problems from rhetoric on the path to implementation, unless the State charges (and funds) an agency to conduct ongoing evaluation of its reformed market.

New Jersey. By the early 1990's, New Jersey's individual insurance market had become concentrated into three sectors: commercial insurance plans (that sold only "one life" group plans to self-employed individuals, self-insured association plans (usually domiciled outside the state) and its BCBS plan, which operated (and was subsidized) as the state's insurer of last resort. Fearing financial instability in the BCBS plan, responding to a court ruling that the state's manner of subsidy (via hospital rate discounts) violated ERISA, and experiencing an upsurge in its uninsured population, in 1992 New Jersey undertook sweeping reforms to avoid collapse of its individual market (Swartz and Garnick, 2000). These included:

- guaranteed issue and guaranteed renewal;
- limits on preexisting condition exclusions and portability toward meeting such exclusions;
- pure community rating;
- standardization of all policies (at present, any of four standard indemnity designs and one HMO benefit design);
- a mandatory minimum loss ratio of 75 percent (with "excess" premiums rebated to policy holders); and
- mandatory insurer participation in the Individual Health Coverage Program (IHCP) which requires all insurers either to sell individual coverage or to pay a share of the losses incurred by carriers that sell individual coverage and seek compensation for losses.

Evaluating the results of these reforms, Swartz and Garnick (2000) concluded that New Jersey's individual health insurance market now includes many more insurers than prior to reform, offering consumers greater choice of both carriers and policies. However, while there was evidence of price competition among insurers, premiums remained high and individual coverage did not rise significantly above pre-IHCP levels.

New York. Also responding to the financial stress of its carrier of last resort -- Empire BCBS -- New York enacted broad reform of its individual market in 1993. As amended in 1996, New York's reforms require:

- all-product guaranteed issue and renewal;
- sale of standard HMO and POS plans only;
- pure community rating, adjusted only for location, family size and plan design; and
- a system of risk adjustment reflecting the demographics and presence of high-cost medical conditions among plan enrollees.

Evaluating the results of New York’s reform law, Hall (2000) observed that a “dramatic exodus” of insurers from the market occurred immediately following reform. Others have noted that all but one insurer (Mutual of Omaha) immediately canceled their unmanaged indemnity products, moving all business to managed care (Paul and Chollet, 1994); finally Mutual also closed their indemnity product and left the individual market.

Hall (2000) observes that individual insurance prices in New York remained high (about 40 percent higher than comparable small-group coverage), and price increases (while moderate since the 1996 amendments standardized individual insurance products) exceeded those in the small-group market. While pure community rating (despite risk adjustment) offered significant incentives for adverse selection in a voluntary market (for example, encouraging greater coverage among older adults and discouraging coverage among younger people — a change that insurers mentioned in interviews), Hall found no evidence of the market instability that would suggest an adverse selection spiral. On balance, New York’s reform law produced some new coverage (a New York Department of Insurance study conducted in 1996 concluded that 20 percent of persons covered in the individual market had been uninsured), but apparently did not increase coverage overall.

In its 2000 amendments to the Health Care Reform Act (HCRA), New York has initiated additional reforms intended to moderate the level and growth of insurances prices in both the small-group and individual markets. Effective in January 2001, New York provides “corridor stop loss” to all HMO plans for individual enrollees, paying 80 percent of HMO’s specific losses between \$20,000 and \$100,000 per year.²⁶ At this writing, no projections of the impact of this law are available.

Vermont. Vermont legislated individual market reform in 1993 both in response to BCBS’s mounting losses as the state’s carrier of last resort, and also as part of the state’s serious effort to achieve universal health insurance coverage. Vermont’s individual-market reforms are similar to the provisions enacted in

²⁶For small-group enrollees, New York will indemnify HMOs for specific losses between \$30,000 and \$100,000 per year.

New York (although its rating restrictions on commercial insurers were both looser and phased in).

Vermont's reforms included:

- guaranteed issue of all products;
- mandatory participation by HMOs in the individual market;
- prohibitions on health status as a rating factor and on exclusion riders;
- for BCBS and HMOs, mandatory pure community rating (adjusted only for family size and plan design); for commercial insurers, 1.5:1 rate bands on demographic factors.²⁷

Population surveys conducted by RAND for The Robert Wood Johnson Foundation indicate that private insurance coverage in Vermont increased nearly 2 percentage points between 1993 and 1997; growth in individual insurance coverage accounted for much of this increase in private coverage.²⁸ Hall observed prices rose steeply following reform (average premiums rose 16 percent per year in 1995 and 1996, compared to anecdotal reports of single-digit rate increases in some other states), and then stabilized; but similar increases occurred also in Vermont's small-group market.

While Vermont's reforms did not destabilize the individual market initially,²⁹ many of the agents that Hall interviewed expressed concern about the cumulative impact of commercial insurers' rating practices in general, and on the stability of the state's BC organization and major HMOs in particular. Reviewing the relative rates charged by Vermont's BC organization, HMOs and commercial insurers between 1994 and 1997, Hall found strong evidence that the leading commercial insurers had much better risk selection: indemnity insurers' premiums and claims were less than half those reported by BC and Kaiser /CHP (causing both to pare back their benefit designs in 1997 in an attempt to block further adverse selection).³⁰ While Vermont's insurance department is concerned about driving out the few commercial insurers in its

²⁷Vermont's intention was to sequentially narrow this rate band for commercial insurers, leading to full community rating by all insurers. However, subsequent to the narrowing of commercial rate bands from 2.3:1 to 1.5:1, Vermont's legislature has not acted to narrow commercial insurers' rates further.

²⁸Hall (2000) notes that the enrollment data that insurers report to the state contradict this trend: in 1997, insurers reported 17 percent fewer covered lives in individual insurance products than in 1994. However, these reports are not audited and they contain some obvious inaccuracies that could compromise both the level and trends in the reported data.

²⁹One large commercial insurer apparently had considerable difficulty adjusting to a reformed market and eventually withdrew entirely. Hall (2000) reports that two large insurers, BC and Fortis/Time, increased their rates 14 to 18 percent in 1995 and again in 1996; in 1997 and 1998, BC increased its rates less than 5 percent per year, and Time/Fortis did not raise its rates at all. In 1999, Time/Fortis was granted a 20-percent rate increase. When it was denied a still larger increase in 2000, it withdrew from the individual market entirely.

³⁰Hall (2000) reported that in 1999 Kaiser/CHP announced its intention to withdraw from Vermont. In addition, one source at BC commented that, considering BC's economic disadvantage in rating, it might consider forgoing its tax exemption in Vermont and withdraw entirely from the individual market.

individual market, it nevertheless proposed in 1999 to eliminate commercial insurers' rating flexibility, "leveling the playing field" for BC and the state's HMOs.

One other notable aspect of Vermont's market is the importance of association plans. Vermont (like Kentucky, as described below) excepted association plans from its small-group reforms.³¹ Hall (2000) reports that association business accounted for more than 60 percent of small-group enrollment statewide, and for more than 90 percent of BC's group enrollment in 1997. Via this level of association business, a substantial share of the small-group market can avoid Vermont's small-group community rating law. However, it also drains preferred risk from the individual market, making that market smaller and more volatile, and probably both worsening adverse selection and driving higher prices for coverage.

Washington. Washington was an "early reform" state, that in 1993 passed some of the most comprehensive reforms anywhere in the country. Those included:

- guaranteed issue and renewal;
- limits on preexisting condition exclusions (a maximum look-back and waiting period of three months, respectively) — and an initial open enrollment period during which no preexisting condition waiting periods would apply ;
- a uniform benefits "floor" (in lieu of fully standardized coverage, such as enacted in New Jersey), but all insurance products were required to be either HMO or POS; and
- phased-in community rating, under which insurers would be required to pool individuals and groups for rating, and (at full phase-in) a prohibition on rate variation for age.

Ultimately, Washington's health insurance market reforms would have required large employers and then small employers to offer group coverage to their workers and dependents (anticipating a Federal waiver of ERISA's restrictions); ultimately an individual coverage mandate would be imposed to effect universal coverage.

In 1995, following the demise of national reform and a Republican insurgence in Washington's legislature, Washington's reforms were radically redesigned. Finally, they included only the following:

- insurers must offer a health plan in the individual market with the same benefit design as the Washington Basic Health Plan (a "BHP look-alike"), but could continue also to sell products with greater or lesser benefits than the BHP;

³¹Associations must guarantee issue and community rate within their memberships, and membership criteria cannot be used to exclude high risk. However, they may charge whatever rate is negotiated with their insurer, without regard to the insurer's community rate.

- insurers may age-rate, and they may discount premiums as much as 10 percent for “healthy lifestyles” or other wellness considerations;
- individuals would be rated as a separate market, not pooled with group market experience;
- guaranteed issue, guaranteed renewal, portability, and short look-back and waiting periods on preexisting condition exclusions were retained.

Thus, most of the conventional components of Washington’s reform effort were retained. However, Kirk (2000) notes that the elimination of benefit standardization and coverage mandates set in place significant opportunities for adverse selection that have plagued Washington’s market. In addition to these changes, the legislature also authorized BHP to enroll individuals at unsubsidized rates, adding to an adverse selection spiral that ultimately destabilized Washington’s individual market.

Insurers had strongly opposed Washington’s 1993 reforms. Following their enactment (but prior to implementation) all but one of the national commercial insurers that had been selling individual products in Washington left; and following the 1995 modifications, none returned.³² Because of this exit, and despite repeal of the requirement that all insurance products be either HMO or POS, unmanaged indemnity coverage vanished. In addition, the individual market quickly re-segmented: insurers’ BHP look-alike plans quickly became the effective benefit ceiling, and insurers tailored various lesser benefit designs to attract favorable risk selection.³³ Premiums for the BHP look-alike plans in 1998 were at least twice the premiums for insurers’ custom products, sparking a contentious, protracted and highly publicized battle over rate increases between insurers and the state’s insurance commissioner (Kirk, 2000). In February of 2000, Washington repealed guaranteed issue and other aspects of its individual market reforms, re-opening its high-risk pool to cover uninsurable individuals.

Washington’s reforms were never fully implemented, and in the aftermath of their repeal the state’s major insurers closed their books of business, renewing coverage but not accepting new applicants. Unsubsidized BHP enrollment was ended, but in some counties reopened when Premera Blue Cross (the largest individual insurer and the only insurer writing statewide) closed its book of business and BHP became the only source of new individual coverage in those counties. Washington has no reliable measure of coverage changes following reform. However, considering the significant disruption of Washington’s market following reform and its repeal, it seems unlikely that individual coverage would

³²Kirk (2000) notes that a number of regional Blue Shield plans, a statewide Blue Cross plan and Group Health Cooperative historically have dominated Washington’s individual (and group) market, and that the state had never been “hospitable ground” for national commercial insurers.

³³Kirk (2000) notes that the most pronounced differences were in coverage for maternity care, mental health and substance abuse treatment and prescription drugs. By 1998, most custom products entirely excluded maternity coverage; others capped maternity benefits. All excluded coverage of mental health and substance abuse — including psychotropic drugs such as antidepressants; and all capped coverage of prescription drugs.

have grown or that noncoverage would have declined. Available information from the National Survey of America's Families (NSAF) indicates that individual coverage dropped from 9.2 percent of nonelderly adults in 1997 to 7.8 percent in 1999 — a statistically significant decline that occurred in only one of the other thirteen NSAF states, New Jersey (Urban Institute, 2001). Nevertheless, Washington's rate of individual coverage in 1999 remained significantly above the national average (6.6 percent).

Kentucky. Like Washington, Kentucky enacted sweeping reforms of its individual market, but then subsequently repealed significant parts of the reform package. Kentucky's story is complicated by at least three factors that were not issues in Washington: its legislature meets biennially, giving the governor only two opportunities to have new laws enacted; it did not have the support of health care providers, who were infuriated by a recent provider tax unrelated to Kentucky's health insurance reforms; and Kentucky's initial reforms included a significant loophole, exempting association business from its group and individual market reforms. Enacted in 1994, Kentucky's initial reforms included:

- full standardization of all health plans, with the design of the standard plans to be determined by a newly created health policy board;
- a state-wide purchasing alliance open to all small businesses (with 100 or fewer employees) and “anchored” with mandatory participation by state and other public employees.
- guaranteed issue of all products and guaranteed renewal;
- a six-month limit on both look-back and waiting periods for preexisting conditions, with credit for prior coverage; and
- prohibitions on rating for health status or gender, and bands of 3:1 on rating for age, family composition and location.

The early implementation of Kentucky's reforms, largely in response to ongoing opposition from insurers, was plagued by a number of mid-course administrative decisions that significantly altered both progress toward and the public perception of the 1994 reforms.³⁴ In 1996, a new general assembly retained some aspects of the 1994 reforms, but repealed many significant provisions. Specifically, the 1996 law:

³⁴Kirk (2000) lists these adjustments as: (1) delay of state participation in the purchasing alliance, so that initially only individuals and small groups were enrolled, “robbing the purchasing alliance of ‘six months of success stories’ prior to the 1996 general assembly; (2) allowing insurers to delay moving their policyholders to standardized plans, provided that they did not raise rates in prestandard plans; (3) equivocation over rate approvals, rescinding some approvals in the middle of the state-employee open enrollment period; and (4) allowing the self-insured state employee plan, KentuckyKare, to participate as an insurer in the purchasing alliance, opening enrollment to individuals and small groups, and creating the perception among state employee that their contributions were subsidizing private enrollees.

- retained guaranteed issue, renewal and portability;
- increased the waiting period for preexisting conditions in the individual market to 12 months;
- Retained community rating, but allowed insurers to rate on gender (with a rate band of 1.5:1), occupation, and healthy lifestyles; and raised the composite rate band for all case characteristics from 3:1 to 5:1;
- extended renewal of prestandard policies for an additional 12 months, moving full standardization of policies out more than a year beyond the initial implementation schedule; and
- exempted associations of employers or individuals from both the community rating and the standard benefit requirements.

As Kirk (2000) observes, Kentucky's reform experience became "notorious for the mass exit of insurers from its market...a reaction to reforms whose key provisions were never implemented and whose penetration never exceeded half of the individual market." Despite the public's perception (and the State's announcements) that more than 40 insurers left Kentucky's individual market, Kirk notes that not more than 23 were writing coverage for even 100 lives, and those insurers only stopped accepting new applicants. All other insurers that left the market either were holding fewer than 100 lives or had never sold individual products (although they were licensed to do so). When asked by Kentucky's Department of Insurance in 1997 to explain their reasons for leaving the market, insurers principally pointed to guaranteed issue, the standardization of products and (unrelated to the reforms) Kentucky's process of rate approval as factors in their decision to exit the market; fewer pointed to the rate bands themselves (Kirk, 2000). In 1998, the Kentucky legislature repealed many of the state's remaining reforms, including guaranteed issue, modified community rating and standardization of products.

The complexity of Kentucky's reform experience, the absence of reliable survey information about coverage, and the heated rhetoric of the insurance industry throughout the process to delay implementation and obtain repeal of Kentucky's reforms, make evaluation of Kentucky's experience in conventional terms nearly impossible. Many of the assertions made by Kentucky's largest insurer, Anthem BCBS — that the individual market had become, in effect, a large high-risk pool — in retrospect appear to be vastly exaggerated. Having skimmed much of its preferred business into association plans (exempted under the reform statute from community rating and standardized benefits) Anthem BCBS probably engineering all or some of the adverse selection it alleged in its individual and small-group business. Nevertheless, as Kirk (2000) observes, most of Anthem's spectacular reported losses in 1996 occurred *not* in its individual or small-group business, but in its experience-rated *large-group* business which was not subject to reform.

Evaluation of the impact of Kentucky's reforms on its market is frustrated by the absence of any information about enrollment or premiums prior to reform. The Kentucky Department of Insurance (1997) reported that most insurers failed to report enrollment data as required after reform, making what data were reported essentially unuseable. While the Department believed that rate increases approved after reform were "moderate," it had no data on pre-reform rates and was unable to determine whether insurers had increased or decreased rates following reform.

Massachusetts. Similar to the context of reform in most of the states described above, the financial problems of Massachusetts' insurer of last resort — BCBS — was the principal impetus for reform of the state's individual insurance market. Despite having imposed extremely long waiting periods for guaranteed-issue coverage in order to discourage adverse selection (a 240-day waiting period for all nonemergency coverage, and limited or excluded coverage for preexisting conditions for up to 3 years), BCBS began to slip financially — due both to its role as insurer as last resort and to rating requirements (community rating with public rate hearings for all increases) not imposed on other insurers. Both commercial insurers and newly arriving HMOs in Massachusetts were underwriting coverage aggressively (Kirk, 2000).

Enacted in 1996, Massachusetts' reforms are as follow:

- all insurers covering more than 5,000 lives in the small-group market must guarantee issue any of three standard products in the individual market, which vary only in the extent of managed care (HMO, PPO, or indemnity) ;
- insurers may upgrade the standard product, offering additional benefits or lower cost-sharing; but they may offer only one product of each type;³⁵
- Only *eligible* individuals (people ineligible for coverage in the group market) may purchase coverage in the individual market, and only during specified open enrollment periods.
- Insurers may not impose exclusions or waiting periods for coverage for eligible individuals;
- Insurers may vary rates for age (initially, 2:1 and currently 1.5:1), location (1.5:1) and family composition, but not for health, claims experience or duration of coverage;³⁶ and
- protections that are substantially similar to COBRA's continuation provisions were extended to employees in firms with as few as two employees.

³⁵Insurers with policy holders enroled in prereform plans as of September 1997 have been allowed to renew those policies until July 2000; at present, only standard plans may be offered or renewed.

³⁶Also, the Department of Insurance was authorized to undertake detailed review of all rate increases that placed the insurer's rate 2 standard deviations or more above the average rate for the product type.

In addition, Massachusetts created an advisory board to design the standard products, gather and evaluate data on the individual market, and to make recommendations to the legislature and division of insurance.

Unlike the experience of many other states, the transition to a reformed market in Massachusetts was swift. The state's major insurers — its BCBS plan and nonprofit HMOs — had crafted the state's reforms, and apparently set about implementing them without focusing their efforts on repeal. All of the commercial insurers in Massachusetts' individual market chose to leave the market rather than offer the standard policies. However, ten commercial insurers not before in Massachusetts' market entered after reform and started to offer standard individual policies in 1998.

In the first year, rates for the same products varied “considerably” among insurers — perhaps reflecting uncertainty about experience or the absence of a unified strategy to deter new enrollment. In the second year, rates began to converge. In a market with standard products, most enrollees selected managed care products, and the prices of commercial indemnity products have become much higher than the prices of either HMO or PPO products (Kirk, 2000).

Massachusetts' individual market following reform is smaller than its prereform market, although its uninsured rate has declined. Much of the reason for the decline may relate to Massachusetts' strong economy and the growth of employer-based coverage (also in a reformed market). Much of the decline in the individual market may relate to Massachusetts' having defined persons eligible for individual coverage as those ineligible for group coverage — forcing self-employed workers and their dependents into the group market as “groups of one”. In addition, the enactment of “mini-COBRA” protections may have diverted many people from the individual market into continued group coverage.

9. Summary and conclusions

Despite its small size, the individual health insurance market plays an important role in a voluntary, private-public “system” of health insurance. For people without access to either employer coverage or public coverage, the individual market is their only source of insurance. The individual insurance market accommodates as much as 26 percent of the population that is not insured either in an employer plan or a public program. These include primarily workers and their families without access to employer coverage, but also a significant proportion of self-employed individuals and their dependents. In general, consumers of individual insurance are older than the employer-insured population. They report similar health status but, consistent with greater adverse selection in the individual market, they may use somewhat more health care (although the statistical reliability of utilization differences is unknown).

Prices in the individual health insurance market are notoriously high. Administrative costs for individual coverage (measured as insurance loadings on medical benefits) are commonly a multiple of

(according to one estimate, three times) those in the group market. Insurers may vary their standard (i.e., lowest) rate by any factor that is not prohibited in state law: typically by age, gender, occupation, location and family size. In most states, where insurers are not required to community rate, insurers may rate up individual coverage further (e.g., by a multiple of two) for health status or claims experience. Product prices appear to vary widely within a market, and sometimes not obviously related to differences in product design.

Measured as estimated turnover, the demand for individual insurance appears to be volatile. In the CPS, about one-third of people who report individual coverage during the year also report employer coverage. Presuming that these people are not dually insured, one third enter from or leave to an employer plan. This rate is approximately 10 times that estimated (in the same way) for people with employer coverage. However, the only available estimates of the price- and income- elasticity of demand for individual insurance, estimated for workers, indicate that consumers in this market may be quite price insensitive — or alternatively, that extensive underwriting and denial of coverage in the individual market are major obstacles to consumers who might buy coverage.

Compared to the group market, the individual insurance market is dominated by BCBS and commercial insurers. HMOs, while gaining significant ground in the individual market, accounted for only about a quarter of individual premiums earned in 1997, compared to 45 percent of group premiums earned. Moreover, the supply of individual insurance is highly concentrated: in all states, just three insurers held 50 to 100 percent of the market, measured at the state level. Insurers' average premium volume in the individual market was less than one-fifth of the average premium volume reported among insurers in the group market, and was systematically much smaller in low-population states and among commercial insurers (compared to BCBS plans and HMOs). This low level of average premium volume appears to be evidence of inefficiently small-scale insurer operations in many states, and may portend an ongoing shake-out of the states' individual insurance markets related to cost pressures, irrespective of whether they are active in market reforms.

Available evidence about the impacts of individual health insurance market reforms is mixed. Empirical studies suggest that some types of reform generate changes in supply, but that partial reforms (e.g., some-product guaranteed issue) may have much different effects than fuller reforms (e.g., all-products guaranteed issue). Various studies -- both empirical and qualitative -- have attempted to describe the effects of reforms. However, from the perspective of either economic efficiency or access to coverage, these effects are not adequately documented.

Empirical studies of the impact of reforms on coverage are recent and few, and they offer conflicting results. One study concluded that guaranteed issue (of some or all products) and limitations on preexisting condition exclusions in the individual market increased the rate of uninsured, but oddly, the

study could detect no significant impact on private coverage (considering employer and other private coverage as an aggregate). A second study, considering only coverage among persons with neither private nor public coverage, also concluded that guaranteed issue may reduce the probability of individual coverage. However, no other type of reform had a detectable impact on individual coverage.

More qualitative assessments of state reform offer a somewhat different set of lessons. No state that has implemented reform is sure of its impacts on coverage: in all states, employer coverage has grown with improving labor markets, and individual coverage has declined — irrespective of reforms. Some of the states considered in this review prohibited the sale of pure indemnity products in their individual markets; but some that did not (e.g., Massachusetts and New York) have seen their individual markets convert strongly or entirely to managed care — either HMO or POS coverage. Many of these states had commercial insurers (with characteristically low premium volume and little market share) close their individual products and ultimately leave the individual market. But others (e.g., Massachusetts) have had new commercial insurers enter their market and appear to succeed there. States that had meager information to evaluate the condition of their individual market and insurers in that market (e.g., Kentucky and Washington) appear to have been least able to maintain their reforms against the opposition of insurers in their individual markets.

While no state has observed either lower insurance premiums or greater individual coverage following reform, either would have been an unrealistic expectation. In an environment of major change, insurers are likely to price conservatively, and in fact may set prices intentionally to discourage new enrollment. No premium data are available to detect whether reform states saw systematically different premium increases than other states. Even in states with reliable information about covered lives or population coverage, the growth of group coverage over the mid- and late-1990s has confounded those states' evaluations of their own reforms.

Finally, HIPAA did little to assist people who buy coverage in the individual market, and especially those who “live” in that market without proximate access to employer coverage. The cost of coverage in the individual market remains, of course, its principal problem. However, insurer practices in the individual market arguably contribute significantly to that cost. Insurer underwriting may be more expensive than effective. Insurers' ability to deny coverage and underwrite for health status deters consumers from reacting to price by changing carriers — or even moving between plans offered by the same carrier. Moreover, aggressive underwriting appears to support insurers operating at inefficiently small scale. These potential areas for reform — guaranteed issue and some constraints on insurer products and pricing to ensure stability — may offer the most significant opportunities to assist consumers in the individual health insurance market. By guaranteeing access to coverage and making coverage more understandable, they would greatly improve consumers' ability to compare insurance

policies and prices. Moreover, by improving the transparency of this market, these measures may also improve its efficiency.

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